Testimony of
Steve White, Immediate Past President
On behalf of
The Association of Health Facility Survey Agencies

Thank you for providing this opportunity for the Association of Health Facility Survey Agencies (AHFSA) to participate in this hearing. I am Steve White, Immediate Past President of the Association. AHFSA represents the leaders of state survey agencies across the country. We were established in 1970 to provide a forum for state directors to share information and to work with HCFA, provider organizations, advocates and others to promote quality health care in a variety of health care settings. We continue to believe that surveillance and enforcement activities are the most important and effective means by which the federal and state governments can assure quality health care for beneficiaries. Over the last three years and especially since the unveiling of the President's Initiatives for Nursing Homes the relationship between HCFA and the states has changed. HCFA has moved from a model of total quality management, emphasizing partnership and collaboration with the states in developing improvement strategies, to a model where policies are being developed centrally and with some exceptions with little input from the states. Rhetoric which directs the blame for poor nursing home care to the states has been unfortunate and unfair. This situation is best illustrated by the announcement of the President's Initiatives and complaint initiative. These were centrally-developed HCFA initiatives finalized and announced without prior state input or knowledge and without first considering and securing the resources necessary to implement them . In prior testimony to this Committee, the Association provided summary information demonstrating the continued untenable position the states are facing in trying to meet ever-increasing workload expectations in the absence of commensurate funding increases over the last decade. The states are simply not able to carry out all of HCFA's expectations within existing resources. Although HCFA has been made acutely aware of this fact and has worked to secure additional funding that may be available in the future, they have been unable to adjust national program priorities and have continued to issue additional directives mandating new program activities. Another example is a directive to monitor, at least monthly, facilities in chains that have filed for bankruptcy protection. In some states this is a significant additional workload. It is particularly disturbing to the states therefore, that HCFA, responding to the very real need to strengthen its oversight role, is now undertaking the development of a state oversight and sanctioning process that establishes program standards which ignore these very real and conflicting resource and program priority issues which will prevent many states from meeting these standards. A revised State Operations Manual (SOM) issuance on state performance standards and sanctions is soon to be released. We know that even as HCFA is working on these state performance measures that lack of resources prevents many states from meeting them. We fully agree that HCFA has every right to get what they pay for in their contractual arrangement with the states. We also do not disagree that there should be oversight. Oversight is important and necessary to insure consistency and direction. We do believe however that any sanctions levied against states should be fair and consistently applied from region to region. They should be based upon consistent objective and valid data that is applied uniformly from region to region. HCFA has spent many years and many millions of dollars developing quality indicators for nursing homes that can be used to compare one nursing home with another. These indicators have been developed by professional researchers, validated and tested for reliability. No system presently exists that can identify differences between states and make valid comparisons. There are many issues related to this new policy. This policy can be used to penalize states for simply disagreeing with HCFA on the level or scope of a problem, often a professional disagreement between federal and state surveyors. One section allows the regional offices to recover money from the states if there is disagreement over whether conditions in a nursing home constitute immediate jeopardy for the residents. The guidelines for immediate jeopardy are vague at best and two professionals can disagree over whether food temperatures, restraints, hot water temperatures or many other things constitute immediate jeopardy. If the state determines that immediate jeopardy exists or does not exist and the regional office disagrees

then sanctions can be levied. Another section allows for sanctions against a state if there is a 20% disagreement in deficiencies cited between the regional office and a state regarding survey results over time. The assumption that the regional office is always correct is inaccurate. States have highly qualified and competent survey staff who are at least as qualified as regional office staff. In most cases with the number of surveys they do each year state survey staff are more experienced. State staff have always had the responsibility to cite deficient practices that are sustainable and defensible in an informal dispute resolution, administrative hearing process and court of law. Federal surveyors are not subject to this same legitimate challenge on a routine basis. Another issue relates to a state's ability to challenge differences between the regional office and the state. HCFA has allowed a mechanism to contest findings only when sanctions are imposed. With a 20% disagreement threshold all surveys could lead to sanctions at a later date based upon cumulative survey data. AHFSA has repeatedly requested that states be notified in writing immediately of any problems that might lead to later sanctions in order to correct weaknesses in the survey process or challenge the findings. The new SOM issuance also includes performance standards that states must meet. At present HCFA is not providing the resources to meet all of these standards. Two performance standards are that states must perform all surveys within fifteen months and maintain a twelve month survey average and that states must perform complaint visits according to HCFA policy. HCFA knows quite well that the 12 month average is slipping nationally. While the states support the complaint policy and believe in many cases that complaints should be prioritized ahead of standard surveys once again many states do not have the resources to meet these time frames. Few states in reality have the resources to meet both of these performance criteria and those that do often have significant state resources that are supplementing their activities. HCFA has been told repeatedly by AHFSA that resources are not available to perform all of the work HCFA is requiring of the states but has been unable to get guidance as to how the work should be prioritized. To include performance standards that HCFA is not providing the resources to meet and then threatening to sanction the states for not meeting them is not reasonable. An important and compounding factor in the states' concern about the proposed oversight/sanction process is the historical and ongoing pattern of inconsistency in how HCFA's regulations and guidelines are interpreted from region to region. I want to take a few minutes and note some of the differences. The first and most obvious difference is the difference in philosophy from regional office to regional office and even within consortiums. For example the Kansas City regional office has a reputation of being responsive and supportive. They work towards a relationship that includes collaboration and partnership with the states in their region. They provide feedback after federal surveys and request input from the states on how to solve difficult issues. Other regional offices are on the other end of the continuum. They have provided little ongoing feedback after federal monitoring surveys and have a more regulatory mentality towards the states. Regional offices are also inconsistent in the way enforcement is handled. One example is the termination of nursing homes from the medicaid and medicare program with low level deficiencies. Advocates, providers and most states have come to believe that terminating a nursing home with isolated deficiencies that constitute no actual harm to the resident is not the best solution. Current regulations require that if a nursing home does not come into substantial compliance within 6 months then it must be terminated from the medicare and medicaid program. Regional offices and states in these situations have found many innovative ways to avoid terminating nursing homes with only less serious deficiencies because they do not believe the punishment fits the crime. Reported ways include regional offices ending one survey cycle and starting another one, extending the termination date, or requiring the states to do multiple follow up visits until the facility is finally back in compliance. Other ways include allowing the facility to fix the problem while the surveyors are still on site, cite the deficiency and note in the report that it has been fixed on site or simply change the scope and severity of the deficiency. States can bring the facility back into compliance by not citing additional deficiencies or recommend the termination of the facility. A similar example is the case where a nursing home has corrected all deficiencies that were cited on the original survey by the time of the follow up visit but have other deficiencies. Some regional offices and even states within regions start a new enforcement cycle while others continue towards termination. Some regional offices are very responsive in processing

enforcement cases while others do not meet timeframes. There are also marked differences in the way state budgets are handled. The allocation process of money to the states is both confusing and inequitable. Factors such as the amount of state share, indirect cost rates and other factors lead to wide variations in the amount of money different states have available to them. Some regional offices have full time budget positions that scrutinize and micromanage the states budget process and expenditures throughout the year. Others simply allocate the money to the states and monitor their expenditures through quarterly reports, leaving most of the accountability up to the states. Regional offices give the states widely varying latitude in administering their programs. For example the San Francisco regional office has allowed states and has sometimes participated in trying new and innovative approaches often beneficial to the states while some of the other regional offices are very rigid and don't allow states to deviate from HCFA policies. There are also differences from regional office to regional office on such things as defining what a home health branch office and sub unit are, how bed changes are handled as well as many other things. The federal monitoring survey process is an area where there is a great deal of concern by the states. Even though HCFA central office has required the regional offices to provide clear, concise and timely feedback to the states the variation in what states are receiving is remarkable. Some regional offices like Kansas City are assuring that states receive clear concise written feedback after every survey (as it should be) while other regional offices are providing little feedback at all. Those states that are not getting appropriate feedback cannot correct problems that exist if they are not aware of what the problems are. Although we have not seen the GAO report we have heard that there is a recommendation that HCFA return to doing primarily comparison surveys as the monitoring mechanism of choice. Most states would be opposed to this approach because historically it has not worked well. There are too many factors that influence differences between surveys when they are done at different times. Factors include different resident samples, change in conditions in nursing homes, and different survey team compositions staying different lengths of time and emphasizing different parts of the process. If the intent of the monitoring process is to evaluate state surveyor competency and ability to follow a standardized survey process, then concurrent monitoring represents a more rational approach. Most states have come to believe that limited resources in the survey process should be redirected to where the problems exist. Ideally resources would be available to survey all nursing homes not only on a 12 month average but more often, investigate all complaints within 10 days, monitor financially troubled facilities and do quality follow ups (as many as necessary). The current reality however is limited resources. With the availability of quality indicator data, we believe the process can be reevaluated within statutory parameters and through creative HCFA policy initiatives allow the flexibility to put limited resources where problems exist. This will result in less predictability in the survey process, improved responsiveness to complaints and our ultimate customer the resident and residents' family members. We would like to work with HCFA and other interested parties to develop workable policy initiatives. In closing, I would like to say that, until HCFA provides adequate resources, clear guidance and uniform application of its policies across regions, it is simply premature to issue a procedure which so clearly threatens the states with sanctions for shortcomings often beyond their control. As I have stated before, the states do not object to objective and legitimate criticism if we do not perform and AHFSA pledges to work with HCFA in a cooperative fashion to help develop a system that works. Thank you for the opportunity to testify today on this important issue.